



Department of Health and Social Services
Division of Public Assistance
CHILD CARE ASSISTANCE PROGRAM

HEALTH STATUS REPORT

For Office Use Only

Name: _____

ICCIS Case Number: _____

Dear Health Care Professional: The Child Care Assistance Program (CCAP) provides financial assistance with child care expenses to help adults find and maintain employment so their family can be self-sufficient. One principle of CCAP is that parents must participate in an eligible activity of work, seek work, training or school to receive assistance. In two parent households both parents must participate in eligible activities unless one parent has been determined, by a physician, to be incapacitated.

For Child Care Assistance purposes, incapacitated means "incapable of caring for children in the family by reason of hospitalization or being physically unable to care for a child, as determined by a physician." 7AAC41.365(b)

The person named above has reported being incapacitated. Please evaluate this person's capacity to care for children in the family or need for hospitalization. We need this information from you to determine the family's eligibility to receive child care assistance benefits. Thank you for taking the time to complete this form.

Date of examination: _____

Medical Diagnosis/Condition: _____

1. Does the patient's physical or mental condition limit the patient's ability to work or provide care for children of the family?

☐ Yes ☐ No **If no, stop here.** If yes, please complete the following questions describing the patient's ability to work:

2. Can the patient work or provide care for children of the family in some capacity full-time? ☐ Yes ☐ No **OR**

part-time? ☐ Yes ☐ No If part-time, how many hours per day can they work or provide care for children of the family? _____

3. How long do you expect the condition to limit the patient's ability to work or provide care to children of the family? _____

4. Do any of the patient's medications cause side effects that may impact their ability to participate in a work, training or school environment or provide care for children of the family? ☐ Yes ☐ No

Printed Physician Name		Address	
Physician Signature	Date	Phone	

You may send a fax copy of the completed form to me at the number indicated below. If you have any questions, please call me. Thank you for your help.

Child Care Assistance Program Representative

Job Title

Fax

Telephone